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ABSTRACT

This information packet is designed to aid schools in identifying financial sources that can be used to finance new intervention approaches that emphasize coordinated services. A four-part framework is offered as a guide to thinking about financing efforts to enhance programs and services to children: redeploying available funds, refinancing and freeing funds for reinvestment, raising new revenue, and restructuring financial systems to effect change. The packet includes the following information: (1) maximizing federal financing; (2) funds under the Improving America's School Act of 1994 designed to foster coordinated services; (3) selected references on financial strategies; (4) resource agencies and organizations; (5) financing children's mental health services; (6) Internet resources specializing in assistance related to financing school mental health services; (7) model programs for financing school mental health services; (8) state consultants for financing mental health in schools; (9) funding sources for school-based health programs in Baltimore, Maryland; (10) examples of federal resources for education, comprehensive services, health, social services, housing , and mental health; (11) steps to writing a proposal for a grant; and (12) using alternative reimbursement models for financing school-based health centers. (Individual articles contain references.) (CR)

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*From the Center's Clearinghouse ...**

An introductory packet on

Financial Strategies to Aid in Addressing Barriers to Learning

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UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given to policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- **enhance practitioner roles, functions and competence**
- **interface with systemic reform movements to strengthen mental health in schools**
- **assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools**

Consultation Cadre ***Clearinghouse***

Newsletter ***National & Regional Meetings***

Electronic Networking

Guidebooks ***Policy Analyses***

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Website: http://www.lifesci.ucla.edu/psych/mh/

*In 1996, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. As indicated, one center is located at UCLA; the other is at the University of Maryland at Baltimore and can be contacted toll free at 1-(888) 706-0980.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

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What is the Center's Clearinghouse?

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; eventually it will be accessible electronically over the Internet.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units.* These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site
http://www.lifesci.ucla.edu/psych/mh/

All materials from the Center's Clearinghouse are available for a minimal fee to cover the cost of copying, handling, and postage. Eventually, we plan to have some of this material and other Clearinghouse documents available, at no-cost, on-line for those with Internet access.

If you know of something we should have in the clearinghouse, let us know.

Preface

While it's true that throwing money at problems doesn't solve them, it is also true that complex problems can't be dealt with effectively without financial resources.

With dwindling budgets, a critical focus of all reform efforts is how to underwrite the costs of new intervention approaches. Local, state, federal, public, private -- all sources are being tapped and there is increasing discussion of how to develop new relationships/partnerships and blend resources. As a 1994 document prepared by the Center for the Study of Social Policy notes,* the discussions focus on "political and financial strategies that use current and future resources in new ways and that maximize all available sources of revenue." That document begins by noting the following essential points:

> First is the central principle of all good financial planning, that **programs drive financing**, not the other way around. Financial strategies must be used to support improved outcomes for families and children. And financing strategies which cannot be adequately adapted to program ends should not be used, even when they happen to generate more money than other approaches.
>
> Second, **no single financing approach will serve to support an ambitious agenda** for change. Financing packages should be developed by drawing from the widest possible array of resources. Many individuals or organizations are stuck on one approach to financing (usually the one that involves asking for more state or local general funds). Yet there are many alternatives. Financing is an art not a science, and creativity is the order of the day. In the end, more general funds may be necessary to support system changes, but these will only be forthcoming and deserved if (we) first make the best use of existing resources. . . .

With these points in mind, the Center for the Study of Social Policy offers the following four part framework as a guide to thinking about financing efforts to enhance programs and services for children.

- Redeployment: using available funds (e.g., investment based, capitation based, cut based, and material redeployment)
- Refinancing: freeing funds for reinvestment
- Raising revenue: generating new funding
- Restructuring financial systems: using financial structures to effect change

At times, the challenge of financing needed reforms seems overwhelming, but each day brings new opportunities and information on successful efforts. This packet is designed as an aid in identifying sources and understanding strategies.

> **Financing reform of family and children's services: An approach to the systematic consideration of financing options or "The Cosmology of Financing."* Document from The Center for the Study of Social Policy, 1250 Eye Street, NW, Washington, DC 20005.

Financial Strategies to Aid in Addressing Barriers to Learning

> It is essential that the work of refinancing be closely tied to ... reform... so that refinancing is a means to support a larger vision of long-term fundamental changes in the systems serving children and families, not an end in and of itself.
> *Judith C. Meyers, 1994*

This Introductory Packet contains:

- *Financing of Reforms:* Introductory Overview
- A Quick Overview of Some Basic Resources
  - Selected References
  - Agencies, Organizations, and Advocacy
  - Internet Resources
  - Model Programs for Financing School Mental Health Services
  - Some Names from Our Consultation Cadre
- Funding Sources for School Based Health Programs
- A brief article: *School-Based Health Centers Search For Funding* downloaded from the Alpha Center website
- Examples of Federal Resources
- A Proposal Writing Short Course downloaded from The Foundation Center website
- Excerpts from a document on: Financing School-Based Health Centers

Financing of Reforms

In a 1994 article on financing strategies to support innovative approaches to assisting children and families, Judith C. Meyers of the Annie E. Casey Foundation examines the limitations of current financing policies, which are categorical, inflexible, and crisis oriented, and presents options for refinancing services through (a) redirecting existing funds; (b) maximizing use of federal funding; (c) decategorizing or pooling current program dollars; and (d) seeking additional sources of revenues through taxes or grant support from the private sector.*

What follows are excerpts from her article.

> Many states are looking for new financing strategies to support ... innovative approaches that cut across health, education, mental health, juvenile justice, and child welfare services. . . . In addition to the problem of insufficient resources, the very structure of current financing policies, and patterns reinforces a categorical and crisis-oriented approach that is confusing and difficult to access.

> Most funding for services flows from multiple funding streams that are separately regulated at the federal or state level. Such categorical funding tends to define eligibility in narrow terms, so that programs are funded to address specific problems. . . .

> Care must be taken to ensure that funding approaches are used to help develop a more broadly integrated system . . ., rather than add to the existing categorical approach. . . . Instead of each agency or each level of government operating in a separate, parallel, and, ultimately, inefficient and ineffective manner, problems should be framed broadly across program areas and levels of government, expanding the possible resources available. The financing strategy should support the desired outcomes of program reform, not drive it. Too often, there is a tendency to design the programs to fit the requirements of the funding streams. If the funding strategy is not driven by program priorities, it becomes all too easy to use new dollars to support the status quo or divert funds to other purposes, such as covering an existing budget deficit or meeting other pressing needs defined by a current crisis or political problem.

> There are four major ways that funding can be made available to support building a new delivery system for children and families, three of which do not require raising new dollars. These include (a) redeploying or redirecting existing funds so that they produce the results sought through programmatic reform; (b) maximizing the use of allowable federal entitlement programs; (c) decategorizing and pooling funding; and (d) raising new revenue through taxes, donations, or fees.

* Meyers, J.C. (1994). Financing strategies to support innovations in service delivery to children. *Journal of Clinical Child Psychology, 23,* 48-54.

Redeployment of Funds

> . . . If existing monies are shifted or redeployed from "deep end" to "front end" services, this shift will drive change in the way services are used, rather than just add new services. . . .

It is important to recognize that redirecting dollars is more than a technical matter. This strategy forces an examination of the use of current resources before new funding decisions are made. This is a difficult process that requires political commitment, as there may be strong opponents to a shift in orientation . . . . A redeployment strategy, similar to any other financing strategy, is more likely to be successful when linked to a broader commitment to reform the way services are delivered to children and families. Rather than simple budget cutting, in which low-priority items are cut and the money is used for higher priority items, in a redeployment strategy there is a conceptual relation between the program cut and the newly funded one, with a predicted return on investment. . . .

In addition to redirecting dollars, staff and other resources can be redeployed from traditional services to more community-based approaches. For example, staff can be reassigned to schools or other community sites, or schools can provide space for family support programs or school-based clinics. These redeployment strategies are short term in nature. Funds can be shifted from one program to another within the same fiscal year, anticipating immediate savings as a result of the development of the new community-based services. Longer term redeployment strategies involve investments in prevention programs, such as HeadStart, family support centers, and parent training, that result in longer term savings as children and families who benefit from these services are diverted from needing more intensive, expensive services in the future.

Maximizing Federal Financing

Many of the interventions being developed in state and local reform initiatives involve services that can be paid in full or in part through federal entitlement programs. Due to the complexity of federal financing and the difficulty of coordinating activity among agencies or levels of government, however, states are not taking full advantage of the opportunities and are assuming these costs with state or local dollars. *Refinancing, as* this shift from the use of state and local government dollars to federal dollars is often called, is a strategy used to capture these currently untapped federal revenues without increasing state budgets, thereby releasing dollars for investment in more community-based alternatives. The primary opportunities for refinancing occur through the use of funds under several titles of the Social Security Act (a) Title XIX -- Medicaid, (b) Title IV-E -- foster care and adoption assistance, and (c) Title IV-A -- the emergency assistance program (U.S. Congress, 1992).

Medicaid. The Medicaid program was established in 1965 under Title XIX of the Social Security Act of 1935 (U.S. Congress, 1992). It is federally administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (DHHS). Although often viewed as a unified financing program, Congress and the HCFA set broad federal guidelines for the program, with a set of separately available and authorized benefits. States have considerable flexibility in formulating eligibility, benefits, and reimbursement policies.

The Medicaid program offers a number of opportunities to refinance services. Many states are turning to Medicaid to help fund a more coherent system of health, mental health, special education, and social services for children and families. Medicaid can be used to pay for a variety of activities for children and their families in a range of settings, including school clinics, satellite sites in family support centers, or the home (Fox & Wicks, 1991; Fox, Wicks, McManus, & Kelly, 1991).

Medicaid options that are available to states to support innovative programming include the following (CSSP, 1988):

1. Case management: States can provide case management services to eligible individuals to assist in gaining access to needed medical, social, educational, and other services. ...

2. Clinic services: Clinic services include preventive, diagnostic, therapeutic, and rehabilitative outpatient services furnished by or under the direction of a doctor. ...

3. Rehabilitation services: Community-based services geared toward psychosocial rehabilitation and assistance as an alternative to residential care can be reimbursed. ...

4. Early and periodic screening, diagnosis and treatment (EPSDT): States are required to provide early and periodic health and mental health screening, diagnosis, and treatment services to all Medicaid eligible recipients under the age of 21 and to provide treatment to correct or ameliorate defects or chronic conditions found. ...

5. Personal care services: Services that provide both patient care of a nonskilled nature and household or chore services necessary to prevent or postpone institutionalization may be covered. ...

6. Home and community-based waivers: Under a waiver of certain statutory requirements, states can offer an array of home- and community-based services that are designed to prevent institutionalization but are not included in the state Medicaid plan. ...

7. The 1915(a) option: Section 1915(a) of the Social Security Act (U.S. Congress, 1992) allows for a state to contract with a health maintenance organization, a prepaid health plan, or other service organizations to serve a defined group of enrollees in a particular geographic area on a prepaid or per capita basis. The package of services may include those not otherwise reimbursed under the state Medicaid plan, allowing enormous flexibility to develop specific services to meet the individual needs of clients. ...

8. Administrative activities: Medicaid will reimburse 50% of administrative costs, which can be broadly defined. ...

Administrative costs are easier to bill and recoup than treatment costs and can provide a way to enhance the capacity of local school districts, local health departments, and other community agencies to identify and serve high-risk children. For example, the costs of a public health nurse engaged in EPSDT outreach, notifying a parent when it is time for a child to receive screening services, scheduling appointments for the family, and assisting with transportation to appointments and follow-up can all be covered as administrative activities. There is an enhanced rate of 75 % for any administrative activity that must be performed or supervised by a skilled medical professional.

Foster care and adoption assistance. Title IV-E is the, title of the Social Security Act of 1935 that provides funding for state foster care and related expenditures. Children entitled to IV-E reimbursement are those who were eligible for Aid to Families with Dependent Children at the time

of their removal from home, or would have been eligible if application had been made, and those for whom proper judicial procedural requirements for protection of children's rights were in place.

Federal reimbursement is provided for three broad categories: (a) out-of-home maintenance costs, including food, clothing, shelter, supervision, and related costs for children in licensed family, group, or institutional care; (b) administrative costs, including such functions as eligibility determination, case planning and management, and referral to service; and (c) training costs, including a wide range of training for child welfare workers, foster parents, and others in the foster care system.

Common ways that states can enhance the amount of federal reimbursement they claim through Title IV-E include extending the use of Title IV-E from the child welfare system (where it is traditionally used) to the mental health and juvenile services area and improving the administration of the program so that a larger number of children are found eligible and a larger range of activities are covered. States tend to underestimate their claims in these areas largely because it is a time consuming process. The CSSP (1991, p. 17), a Washington, DC organization that has worked with states and localities over the past decade to help them restructure and refinance their human service programs, estimated that states could increase their federal reimbursement through Title IV-E by several million dollars simply by taking the administrative steps necessary to certify more poor children as eligible for reimbursement. They estimate that 50% to 70% of children in foster care are eligible for Title IV-E benefits.

Emergency assistance. Title IV-A of the Social Security Act of 1935 provides 50% federal reimbursement for state emergency assistance programs for needy families with children. States have been given wide latitude to define which emergencies are covered in their state plan and what types of assistance can be provided to families. Traditionally, emergency assistance has been used to support economic crises when a shortage of money may lead to an eviction or the shut-off of utilities. A number of states, however, have expanded the definition of emergency to include families who are at imminent risk of having a child removed from home. Under these circumstances, states can claim the costs of such services as family preservation, emergency shelter, and respite care. In these states, the qualifying emergency is defined in the state plan as risk of abuse or neglect or risk of out-of-home placement. Costs of foster care placement for the child can also be claimed when removal and out-of-home care are part of a emergency response. Administrative costs are also allowable. Some states have defined the investigation work of protective service workers as part of the emergency assistance eligibility process. The primary limitation of the use of Title IV-A benefits is that they can only be used once in any 12-month period for a particular family, though they can cover expenses for a 3- to 6-month period.

Decategorizing Funding Streams

> . . . By removing the strings attached to funding by categorical programming, or decategorizing funds, services can be tailored to the child's needs . . . . By decategorizing the funding, workers can select the most appropriate blend of services, rather than the most easily funded. Decisions can be driven by the needs of the child, rather than dictated by funding stream restrictions.
>
> A review of integrated funding models developed in other states by a Minnesota legislative task force (Children's Integrated Fund Task Force, 1993) revealed that integrated funding resulted in better coordination of services, more collaborative working relationships, and improvements in the local service delivery system. Multiagency pooling of currently expended dollars, both public and private, resulted in the ability to leverage greater federal entitlement reimbursements for service-system development and reform than would have been possible through any single agency operating on its own. . . .

Conclusion

. . . This article has described ways that states and communities can find resources to support reforms . . . . None of these strategies, however, is easy to implement. Political commitment has to be established and maintained at all levels of government. Frontline workers and managers must be trained. Program staff across agencies and systems must come together to develop new approaches to serve children more holistically . . . . Administrative mechanisms must be developed, supported, and implemented to maintain the new financing mechanisms. Thus, it is essential that the work of refinancing be closely tied to . . . reform . . . so that refinancing is a means to support a larger vision of long-term fundamental changes in the systems serving children and families, not an end in and of itself.

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U.S. Congress, House of Representatives, Committee on Ways and Means. (1992). *Overview of entitlement programs: 1992 green book: Background material and data on programs within the jurisdiction of the Committee on Ways and Means.* Washington, DC: U.S. Government Printing Office.

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Virginia General Assembly. (1992). *Comprehensive Services Act for at risk youth and families* (pp. 745-759). Richmond, VA: Author.

Financing for Schools to Enhance Coordination of Programs and Services to Address Barriers to Learning

Title XI of the Improving Americas Schools Act of 1994 is designed to foster coordinated services to address problems that children face outside the classroom that affect their performance in schools.

Under this provision, school districts, schools, and consortia of schools may use up to 5 percent of the funds they receive under the Elementary and Secondary Education Act (ESEA) to develop, implement, or expand efforts to coordinate services.

The intent is to improve access to social, health, and education programs and services to enable children to achieve in school and to involve parents more fully in their children's education.

Among the barriers cited in the legislation as impeding learning are poor nutrition, unsafe living conditions, physical and sexual abuse, family and gang violence, inadequate health care, unemployment, lack of child care, and substance abuse.

Interested applicants should contact:

Susan Wellman
Program Analyst, Title XI
Elementary and Secondary Education
600 Independence Ave., SW (Portals Room 4400)
Washington, D.C. 20202-6132
(202)260-0984

Several school districts have already initiated efforts under Title XI. You may want to contact either of the following to get a sense of their approach.

Sally Coughlin, Assistant Superintendent
Student Health and Human Services
Los Angeles Unified School District
450 N. Grand Ave.
Los Angeles, CA 90012
(213)625-5635

Jenni Jennings, Coordinator
Youth & Family Centers
Dallas Public Schools
425 Office Parkway
Dallas, TX 75204
(214)827-4343

A Quick Overview of Some Basic Resources

Financial Strategies: Selected References

I. Discussions of Funding Sources and Models

Full-service schools: A revolution in health and social services for children, youth, and families.
J. G. Dryfoos. San Francisco, CA: Jossey-Bass, Inc., 1994.

Funding and financing for programs to serve K-3 at-risk children: A research review.
K. F. Jordan, T. S. Lyons, & J. T. McDonough. Washington, DC: National Education Association, 1992.

Financing reform of family and children's services: An approach to the systematic consideration of financing options: Or "The Cosmology of Financing."
Document prepared by The Center for the Study of Social Policy (1994).
Available from 1250 Eye Street, NW, Washington, DC, 20005.

Rethinking school finances.
A. Odden. San Franciscio, CA: Jossy-Bass, Inc., 1992.

State financing strategies that promote more effective services for children and families.
F. Farrow (1991). In: *Effective services for young children: Report of a workshop.* L. B. Schorr, D. Both, & C. Copple (Eds.). Washington, DC: National Academy Press.

Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children.
Government Accounting Office. GAO/HEHS-96-35, 1996.

Integrating Title I and Title VII: The evolving model of Dearborn public schools, Michigan.
S. Arraf, M. Fayz, M. Sedgeman, R.K. Haugen (1995). Document prepared by the National Clearinghouse for Bilingual Education.
Available from The George Washington University, Graduate School of Education and Human Development, Washington, DC.

Summary of selected funding sources for school-based services.
E.R. Dunn-Malhotra & A. Shotton (1990). Document prepared for Urban Strategies Council.
Available from Youth Law Center, 114 Sansome Street, Suite 950, San Francisco CA 94104-3820.

Financing strategies to support innovations in services delivery to children.
J. Meyers (1994). *Journal of Clinical Child Psychology*, 23(Suppl.), 48-54.

State initiatives to provide medical coverage for uninsured children.
C. DeGraw, M.J. Park, J.A. Hudman (1995). *The Future of Children*, 5(1), 223-231.

II. Issues and considerations

Legal, professional, and financial constraints on psychologists' delivery of health care services in school settings.
S. T. DeMers, P. Bricklin (1995). *School Psychology Quarterly, 10,* 217-235.

School-linked services: pitfalls and potential.
M. W. Kirst (1994). *Spectrum: the Journal of State Government, 67,* 15- 25.

Thinking about kids and education. (federal aid to family services and education)
H. Howe, II (1993). *Phi Delta Kappan, 75,* 226-228.

Satisfying and stressful experiences of first-time federal grantees.
S. F. Jacobson, & M. E. O'Brien (1992). *IMAGE: Journal of Nursing Scholarship, 24,* 45-49.

Foundations seed non-hospital primary care networks. (W.K. Kellogg Foundation, Robert Wood Johnson Foundation)
F. Sabatino (1992). *Hospitals, 66,* 22-23.

School-based health centers and managed care health plans: Partners in primary care.
D.J. Zimmerman & C.J. Reif (1995). *Journal of Public Health Management Practice,* 1(1), 33-39.

The unfinished journey: Restructuring schools in a diverse society, A California Tomorrow Research and Policy Report from the Education for a Diverse Society Project.
C. Dowell & L. Raffel (1994). *A California Tomorrow Publication,* 5-11

Issues in financing school-based health centers: A guide for state officials.
Document prepared by Making the Grade (1995).
Available from The George Washington University, Washington, DC.

Potential sources of federal support for school-based and school linked health services.
J. Steinschneider (1993). *Education and Urban Society,* 25(2), 166-74.

Agencies, Organizations, and Advocacy

There are many agencies and organizations that are relevant with respect to this topic. A few are listed below.

Education Funding Research Council

4301 North Fairfax Dr. -- Suite 875
Arlington, VA 22203-1627
(800) 876-0226
Fax: (703) 528-6060

Description: The council publishes the Funding Resource Bulletin, a quarterly resource for education funding news as well as subscription information for many other resources distributed by the council including: 'Guide to Federal Funding for School Health Programs,' 'Guide to Federal Funding for Education.' ' Federal Grant Deadline Calendar,' 'The Grantseeker.' ' The New Title I Compensatory Education Program: An Analysis,' and ' Tapping Private Sector Funding.'

Research and Training Center on Family Support and Children's Mental Health

Portland State University
P.O. Box 751
Portland, Oregon 97207-0751
(503) 725-4040

Description: The center publishes information relevant to mental health financing and programming. A useful example of their work is included in this introductory packet.

The Twentieth Century Fund

41 East 70th Street
New York, New York 10021
(212) 535-4441
Email: xxthfund@ix.netcom.com

For information, please see the Internet Resources section.

Annie E. Casey Foundation

701 St. Paul Street
Baltimore, MD 21202
(410) 223-2948
Fax: (410) 223-2956
Email: bill@aecf.org

For more information, please see the Internet Resources section.

Center on Budget and Policy Priorities

820 First Street, NE Suite 510
Washington, DC 20002
(202) 408-1080
Fax: (202)408 1056

For more information, please see the Internet Resources section.

The Alpha Center

1350 Connecticut Avenue, NW
Suite 1100
Washington, DC 20036
(202) 296-1818
Fax: (2020) 296-1825

For more information, please see the Internet Resources section.

The Commonwealth Fund

One East 75th Street
New York, New York 10021-2692
(212) 535-0400
Fax: (212) 606-3500
Email: mlr@cmwf.org

For more information, please see the Internet Resources section.

The Henry J. Kaiser Family Foundation

1450 G Street NW, Suite 250
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Email: info@familiesusa.org

For more information, please see the Internet Resources section.

Public/Private Ventures

One Commerce Square
2005 Market Street, Suite 900
Philadelphia, PA 19103
(215) 557-4469
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Email: ppy@epn.org

For more information, please see the Internet Resources section.

Financing Children's Mental Health Services

Prepared by the Research and Training Center on Family Support and Children's Mental Health

One of the most difficult tasks confronting families whose children have serious emotional disorders is paying for treatment and other necessary services. Expenses frequently exceed the limits of family insurance policies--especially if psychiatric hospitalization, residential treatment, or other out-of-home placement is involved. In addition to personal resources and family insurance coverage, other possible sources of funds to pay for services include: (1) Title IV-E of the Social Security Act (1980); (2)Title V of the Social Security Act (1981); and (3) Medicaid (Title XIX of the Social Security Act; 1965).

Insurance. Families whose children have serious mental, emotional or behavioral disorders have special health insurance needs. Factors to be considered in selecting an appropriate health plan include: (1) enrollment requirements or limitations (such as precluding coverage of preexisting conditions); (2) cost (premium, deductible, co-payment, lifetime maximum limitations); (3) covered benefits (i.e., are mental health services covered?); and (4) whether the family's current providers participate in the insurance plan.

Title IV-E. Also known as Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, this law sets forth the conditions under which states may receive federal dollars for out-of-home placement. Many child welfare personnel *mistakenly* believe that states cannot be reimbursed with federal funds unless legal custody has transferred to the state and therefore require parents or guardians to relinquish legal custody to obtain services. In fact, voluntary placement agreements are permissible. Moreover, a judicial determination that the voluntary placement is in the best interests of the child is required for federal reimbursement only where the placement extends beyond 180 days.

Title V. Also known as the Maternal and Child Health Services Block Grant or as state program for Children with Special Health Care Needs (CSHC), this law serves all women fifteen to forty-four years of age and all children from birth to age twenty-one. Title V is an important funding source for early intervention services (screening and intervention programs to identify and help children at risk for emotional problems and their families). Although each state may determine what Title V services it will offer, most Title V state agencies provide initial diagnostic services, as well as case management (coordinating the assessment of needs and provision of services to a child and family; advocating for the child and family) and limited treatment services. Information on applying for the Title V program is available through state health departments or family pediatricians.

Title XIX/Medicaid. Medicaid is a federal program that reimburses states for a proportion of the costs of providing medical care to low income people. Early and periodic screening, diagnosis and treatment services for children (EPSDT) are provided by all state Medicaid programs. Due to recent Congressional changes, states are required to: (1) provide children served under Medicaid with EPSDT screening when determined to be medically necessary by a qualified professional; and (2) where an EPSDT screening discovers a condition, reimburse related treatment services that are allowed under federal law, even if these services are not offered to other state Medicaid recipients.

Much of the medical care provided with Medicaid funds has been provided in hospitals. Hospital care is both expensive and often not the most appropriate setting to provide services to children with

emotional disabilities. States may seek Medicaid waivers for home and community-based care (such as case management services, day treatment, crisis management and emergency services) if the community care is no more expensive than the hospital/institutional care. Mental health advocates are working to change state Medicaid
plans to increase the provision of Medicaid-eligible mental health services to children and youth. Information on applying for Medicaid funding is available through county health, welfare, or social service agencies.

References/Resources

Cox, Ni & Gittler, J. (1986). *The Title V state programs and the provision of case management services for children with special health care needs.* National. Maternal and Child Health Resource Center, College of Law Building, University of Iowa, Iowa City, Iowa 52242; (319) 335-9046.

Fox, H.B. & Yoshpe, R. (1987). *An explanation of Medicaid and its role in financing treatment for severely emotionally disturbed children and adolescents.* Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016; (202) 364-4164.

Koyanagi, C. (1988). *Operation help: A mental health advocate's guide to Medicaid.*

National Mental Health Association, 1021 Prince Street, Alexandria, Virginia 22314-2971; (703) 684-7722.

McManus, MA. (1988). *Understanding your health insurance options: A guide for families who have children with special health care needs.* Association for the Care of Children's Health, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016; (202) 244-1801.

McManus, MC. & Friesen, B.J. ('1988). Barriers to accessing services. Relinquishing legal custody as a means of obtaining services for children with serious emotional disabilities. *Focal Point* 3(3). Research and Training Center on Family Support and Children's Mental

Health, Portland State University, P.O. Box 751, Portland, Oregon 97207-0751; (503) 7254040.

Additional Resources

Craig, R.T. & Wright, B. (1988). *Mental Health financing and programming. A legislator's guide.* National Conference of State Legislatures, 1050 17th Street, Suite 2100, Denver, Colorado 80265; (303) 623-7800.

Fox, H.B. & Yoshpe, R. (1987). *Medicaid financing for early intervention services.* National

Center for Networking Community Based Services, Georgetown University Child

Development Center, 3615 Wisconsin Avenue, N.W, Washington, D.C.; (202) 687-8635.

Lakin, K.C, Jaskulski, T.K, Hill, B.K., Bruininks, R.H., Menke, J.K, White, C.C., & Wright, E.A. (1989). *Medicaid services for persons with mental retardation and related conditions.* Center for Residential and Community Services, Institute on Community Integration, University of Minnesota, 207 Pattee Hall, 150 Pillsbury Drive S.E., Minneapolis, Minnesota 55455; (612) 624-6328.

Pizzo, P. (Producer). (1988). *Meeting the medical bills.* (Videotape). National Center for . Clinical Infant Programs, 733 Fifteenth Street, N.W., Washington, D.C. 20005; (202) 3470308.

Williams, S. (1988). *Using Medicaid to increase funding for home- and community-based mental health services for children and youth with severe emotional disturbances. A report on a CASSP workshop held on September 14 and 15. 1988 in Bethesda, Maryland.* CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road, N.W., Washington, D.C. 20007; (202) 687-8635.

October 1990

Internet Resources Specializing in Assistance Related to Financing School Mental Health Services

The following is a list of sites on the World Wide Web that offer information and resources related to financing school mental health services. This list is not a comprehensive list, but is meant to highlight some premier resources and serve as a beginning for your search. Also, at the end of this section is a guide to using the ERIC Clearinghouses on the Internet.

The Internet is a useful tool for finding some basic resources. For a start, try using a search engine such as Yahoo and typing in the words "funding and mental health" or "grants and schools". "Financing" is probably too general. Frequently if you find one useful Webpage it will have links to other organizations with similar topics of research.

Listed below are some Websites that contain information related to special education:

GrantsWeb WWW HomePage
Address: http://infoserv.rttonet.psu.edu/gweb.htm
Description: GrantsWeb is a starting point for accessing grants-related information and resources on the Internet. GrantsWeb organizes links to grants-related Internet sites and resources, including funding opportunities, grants data bases, policy developments, and professional activities.

Foundation Center
Address: http://FDNCENTER.ORG
Description: The Foundation Center is an independent nonprofit information clearinghouse established in 1956. The Center's mission is to foster public understanding of the foundation field by collecting, organizing, analyzing, and disseminating information on foundations, corporate giving, and related subjects. The audiences that call on the Center's resources include grantseekers, grantmakers, researchers, policymakers, the media, and the general public. The Foundation Center's database contains comprehensive information on more than 40,000 grantmaking foundations and direct corporate giving programs. The contents of the Center's database are available to subscribers through http://www.dialog.com/dialog/dialog1.html. Phone: (212) 620-4230, ext. 2451.

National Institute of Mental Health
Address: gopher://gopher.nimh.nih.gov:70/11/grants
Description: This gopher web page provides information about grants and contracts.

National Institute of Health
Address: http://www.nih.gov/nihnew.html
Description: This website provides information about grants and contracts.

Health Resources and Services Administration
Address: http://www.os.dhhs.gov
Description: This website provides listings of federal grants and contracts.

Health Resources and Services Administration
Address: http://www.hrsa.dhhs.gov
Description: Includes an overview of programs, news, grants, contracts, and consumer information.

Quinlan's Public School Bulletin- Grants and Funding Opportunities
Address: http://www,quinlan.com/gsdh.htm
Description: This website provides an up-to-date listing of available grants, foundations, school programs, and business partnerships from across the country. Includes important deadlines from the Federal Register, online resource listings, and regional grants update, plus an insidetrack on the Department of Education.

Public/Private Ventures
Address: http://tap.epn.org/ppv/#are
Description: This website describes P/PV's numerous programs and initiatives including Community Change for Youth Development (CCYD), a project which mobilizes public and private institutions, resources and policies to shape communitywide networks of youth supports and opportunities.

Alpha Center
Address: http://www.ac.org/httpdocs/bio.html
Description: The Alpha Center works to shape health care policy that is in the broad public interest. This website helps serve the Alpha Center's primary goal: to bring state leaders, health services researchers, health care workers and foundations together for enlightened exchanges of information. These forums forge links between those making policy decisions and those who have the knowledge to inform those decision. The website describes the Center's core capacities and includes useful articles, an example of which is included in this introductory packet.

National Education Association FAQ
Address: http://www.nea.org/info/faq.html
Description: NEA is America's largest organization committed to advancing the cause of public education and is active at the local, state, and national level. This website has many links to useful resources.

The Commonwealth Fund
Address: http://www.cmwf.org/cwfhist.html
Description: This philanthropic foundation provides grants for improving health care services, bettering the health of minority Americans, developing the capacities of children and youth, and advancing the well-being of elderly people. This website provides grant application information.

The Henry J. Kaiser Family Foundation
Address: http://www.kff.org/about.html
Description: This health care philanthropy foundation 's work is focused on health policy, reproductive health, HIV policy, and health and development in South Africa. This website provides grant application information.

The Rockefeller Foundation
Address: http://www.spo.berkeley.edu/RA/06_96/articles/rockefeller.html
Description: The Foundation currently seeks proposals on selected topics including population/health sciences and programs partly funded by the foundation.

Annie E. Casey Foundation
Address: http//web-cr01.pbs.org/nic/casey_foundation.html
Description: A private charitable organization dedicated to fostering public policies, human-service reforms, and community supports that more effectively meet the needs of today's vulnerable children and families. The foundation makes grants that help states, cities, and communities fashion more innovative, cost-effective responses to these needs. Website provides information about grants.

Center on Budget and Policy Priorities
Address: http://www.cbpp.org/info.html
Description: The Center is a principal source of information and analysis on a broad range of budget and policy issues, with an emphasis on those affecting low- and moderate-income Americans. The Center analyzes such matters as federal and state budget and tax policies, poverty and income trends, wage and employment issues, and welfare, job training, and housing issues. Website includes recent analyses, publication lists, and internship information.

The Twentieth Century Fund
Address: http://epn.org/tcf.html
Description: This website describes the foundation's research, publications, and policy recommendations which focus on progressive public policy. Publications can be ordered through this website.

The Pew Charitable Trusts
Address: http://www.midwestorganic.org/pew.html
Description: A national and international philanthropy which supports nonprofit activities in the areas of culture, education, the environment, health and human services, public policy and religion. Website provides grant application information.

The American Prospect Online
Address: http://epn.org/prospect.html
Description: This website features the electronic version of *The American Prospect* magazine. Includes articles on educational reform, health care reform, economics, politics, and welfare policy.

Economic Policy Institute
Address: http://epinet. org/
Description: The website of this nonprofit, nonpartisan think tank which seeks to broaden the public debate about strategies to achieve a prosperous and fair economy. Includes recent institute reports covering topics such as education reform. Specifically addresses the movement to hire business firms to manage public school or public school systems. Contains publication ordering information.

Families USA
Address: http://epn.org/families.html#about
Description: The website for this national nonprofit organization which advocates high-quality, affordable health and long term care for all Americans. Families USA works at the national, state, and grassroots levels with organizations and individuals to help them participate constructively in shaping health care policies in the public and private sectors. Website contains publication ordering information and many links via HealthLink USA.

Russell Sage Foundation

Address: http://www.epn.org/sage.html#about

Description: This foundation gives grants for research in the social sciences and publishes books that derive from the work of its grantees and visiting scholars. Website provides grant application information.

The Center for Law and Social Policy

Address: http://epn.org/clasp.html

Description: This national public interest law firm has expertise in both law and policy affecting the poor. CLASP seeks to improve the economic conditions of low-income families which children and secure access for the poor to our civil justice system. Website includes abstracts of recent publications.

The Robert Wood Johnson Foundation

Address: http://www.rwjf.org/main.html

Description: This foundation is the nation's largest health care philanthropy, making grants to programs and projects designed to improve the health and health care of Americans. The website describes how to apply for grants.

W.K. Kellogg Foundation

Address: http://www.cerritos.eedu/cerritos/development/funders_kellogg.html

Description: This foundation makes grants to programs focusing on youth, higher education, community based health services, and leadership. Funds are available for seed money for pilot projects. This website includes grant application information.

AskERIC

AskERIC is a very useful Internet resource that allows you to search the ERIC Clearinghouse. On the following page is a guide to using AskERIC. For a discussion of the ERIC Clearinghouses, see the reference section of this introductory packet.

Gopher It! Accessing Department of Education Grant Information on the Internet: National Institute on the Education of At-Risk Students

Description: Looking for information on U.S. Department of Education (ED) programs and funding opportunities? If you have access to the Internet, you can obtain information through the ED Gopher, a service provided under the auspices of the ED Institutional Communications Network (INet) project, as well as other government gopher servers. At these sites, you'll find information on discretionary grants, as well as on grants distributed by formula, and on contracting opportunities. There are a variety of on-line sources of information, including: ED Grants Announcements. Although the Federal Register contains the official application notices for discretionary grants, ED also maintains announcements of upcoming competitions in its gopher site. For access, gopher to gopher.ed.gov, then select "Announcements, Bulletins, and Press Releases," followed by "gopher://gopher.ed.gov:70/11/announce/competitions">"Current Funding Opportunities."

Some Model Programs for Financing School Mental Health Services

The following abstracts describe specific funding challenges as well as restructuring programs which emphasize funding reform strategies. These abstracts were downloaded from the ERIC Clearinghouse. Complete documents can be ordered through ERIC. For a discussion of how to access the ERIC Clearinghouse, see the reference section of this introductory packet.

Notes from the Field: Education Reform in Rural Kentucky, 1991-1992
This document consists of the first five issues of a serial documenting a 5-year study of the implementation of the Kentucky Education Reform Act (KERA) of 1990 in four rural Kentucky school districts. The first issue provides a brief overview of KERA policies and the status of their implementation in the study districts. It covers: (1) school-based decision making; (2) preschool education; (3) family resource centers and youth services centers; (4) extended school services; (5) political measures; (6) superintendent selection process; (7) termination of teacher contracts; and (8) finance. The second issue focuses on school-based decision making and reports that all study districts are implementing this component on schedule. The third issue reports on the establishment of family resource centers (elementary schools) and youth services centers (secondary schools), based on visits to four centers. The fourth issue features KERA finance measures and analyzes how these measures have affected the study districts. The analysis reveals that education funding increased substantially in the four rural districts since the passage of KERA. Most of the new funding went to salary increases, instructional and library supplies, and programs to help at-risk students. Although it is not possible to study the equalization effects of KERA with such a small sample, per pupil revenue appeared to become more equal among three of the four districts. The fifth issue summarizes teacher focus- group discussions in each of the four school districts.
ERIC Document #: ED360120

A Tightening of the Screws: The Politics of School Finance in Florida
This paper presents an overview of challenges to the Florida school system in 1995, some of which include rising student enrollment, an increase in racial and ethnic minority populations, and a tax base that is failing to keep pace with growth. With regard to student performance, large numbers of high school graduates are not prepared for successful college work. However, Florida has one of the most equally distributed systems of public school funding in the country, the Florida Education Finance Program (FEFP). Although the overall fiscal health of the state remains strong, education has not benefitted because of an increasingly constrained state government revenue base and competition from other public-sector programs. In addition, a law has been filed that alleges inadequate funding in three areas: the additional fiscal burdens caused by rapidly increasing numbers of students who are expensive to educate; the state-mandated improvement and accountability plan (Blueprint 2000) that requires higher achievement levels; and underfunded, state-mandated transportation services. Other concerns are the maintenance of the fundamental equity of the state's funding formula and funding-formula changes that negatively affect special needs students. Blueprint 2000, the statewide plan for school-based management, requires school-improvement plans, school-advisory councils, and school report

cards. Another challenge is to focus attention on education in a state which school-age children comprise only 16 percent of the population.
ERIC document #: ED385923

Education Reform: School-Based Management Results in Changes in Instruction and Budgeting
This report responds to a request for information on School-Based Management (SBM) from Senators Edward M. Kennedy and David Durenberger. It answers the following questions: (1) Under SBM, did administrators and teachers change their schools' instructional programs and budgets and, if so, how? (2) What were key similarities and differences in districts' approaches to SBM? (3) How were Chapter 1 programs integrated with SBM? A study of SBM initiatives was conducted in three school districts: Dade County, Florida; Edmonton, Alberta, Canada; and Prince William County, Virginia. Changes in instructional programs included adding all-day kindergarten, extended-day programs, special education and gifted-and-talented programs, and new courses. Changes in budgeting included adjustments in spending on staff, supplies, and equipment. A key similarity in districts' approaches to SBM was that it operated with other district reforms as part of a broader reform strategy. Key differences in the approaches to SBM included how the district allocated funds to its schools, and whether schools or the district developed schools' budgets. The Chapter 1 program was largely not integrated with SBM in Dade County and Prince William County. Proposed legislation to reauthorize Chapter 1 would decentralize some control over the program, moving it from districts to schools. The appendices contain objectives, scope, and methodology; results of a multivariate analysis; waivers obtained by schools; school and district staff's remarks about SBM; and major contributors to this report.
ERIC Document #: ED383033

Paths to School Readiness: An In-Depth Look at Three Early Childhood Programs
This report provides practitioners in the field of child and family services with important guidelines on early childhood education and family support programs including program design, community collaboration, funding, and staff management. The book presents the five main components of establishing an early childhood education and family support program by drawing on case studies of three exemplary programs: Early Education Services of Brattleboro, Vermont; The Center of Leadville, Colorado; and Family Services Center of Gainesville, Florida. Specific to financing school restructuring, Chapter 7 analyzes several innovative funding strategies and their implications. Chapter 8 contains recommendations for policy makers, including examples of ways in which states can support local efforts at comprehensive services for children and families, and remove barriers to their more efficient implementation.
ERIC document #: ED387214

Reinventing Education: Investigating in People Project
As businesses are remodeling their workplaces into high-performance work organizations, states must reorganize their education systems to accommodate the changing world of work and to produce citizens able to compete in the global economy. This paper is the first in a series of reports by the Investing in People (IIP) Project, which is funded by the DeWitt Wallace-Reader's Digest Fund. It provides an overview of the issues and concerns surrounding school restructuring and provides examples of state reform efforts when available. Following the

preface, acknowledgements, executive summary, and introduction, chapter 1 examines states that are restructuring their entire school systems. Chapter 2 describes various administrative structures, such as school-based management, charter schools, and school choice. The third chapter looks at changing the ways teachers teach, including changes in curriculum, standards, assessment, and instruction methods, as well as a focus on teaching complex thinking skills and meeting minority students' needs. Changes in the way students learn are explored in the fourth chapter, such as class size, multi-age classrooms, school-year length, and alternative schools and programs. Chapter 5 describes the efforts of states at integrating educational and social services. One idea is to coordinate child care, health care, and social services through interagency councils. Chapters 6 and 7 discuss community partnerships and programs for life-long learning, respectively. The final chapter describes the comprehensive education reform legislation passed by Kentucky and Oregon. The appendix contains a list of state contacts.
ERIC Document #: ED370241

Potential Sources of Federal Support for School-Based and School-Linked Health Services
Volume III of a three- volume guide to school-based and school-linked health centers, this document notes that communities that wish to continue existing school-based health clinics or to start new ones may need to explore federal support for health center operations. This manual identifies federal health, education, and social programs which support the kinds of services provided by school health centers. Some of these programs described cover a broad array of health services; other cover specific types of services; still others support demonstration or model projects. For each of these programs, the manual identifies the program's purpose and structure, who may be served with the funds, what services they may receive, major programmatic and administrative requirements for funded service providers, application procedures, and a federal contact person for additional information. The 15 chapters in the manual focus on: (1) the flow of federal funds; (2) Health Care Block Grants; (3) Title V: Maternal and Child Health Services Block Grant; (4) Preventive Health and Health Services Block Grant; (5) Substance Abuse Prevention and Treatment Block Grant; (6) Community Mental Health Services Block Grant; (7) Medicaid; (8) Section 330: Community Health Centers; (9) Drug-Free Schools and Communities- state grants; (10) Title X: Family Planning Services; (11) Women, Infants, and Children (WIC) Program; (12) Social Services Block Grant; (13) Child Care and Development Block Grant; (14) direct grants for innovative, demonstration or special projects; and (15) three state case studies (New Jersey, New Mexico, and California). The manual focuses on requirements found in the federal law. Appendices include: (1) a list of acronyms; (2) a list of federal agencies with responsibility for adolescent services; (3) Medicaid federal financial participation rates by states; and (4) state contacts for selected federal programs.
ERIC Document #: ED365893

Exceptional Children: A Report to the Idaho Legislature
A 1993-94 update on special education program activities and funding in Idaho is presented. After an overview of accomplishments in special education as a whole during 1993-94, activities supporting gifted and talented programs are identified, including a state guide for gifted education, regional planning meetings, curriculum workshops, and on-site technical assistance,. Examples of developments in programs and services involving gifted/talented education at the school district level are cited, and an overview of special education instructional programs and services for children wit disabilities is provided. Recent provisions that affect state special

education funding are noted, and some data on federal funds for Idaho special education are included. Service for children with serious emotional disturbances (SED) is identified as an area of unmet need. Five recommendations to address identification and education of children with SED are offered for the Idaho legislature. Among them are maximizing of Medicaid dollars to provide local in-home and school-based mental health services, family consultation, day treatment, and case management; and establishment of mental health service options in all communities. Statistical tables report on state funds received and state and local funds expended by each school district for the 1993-94 school year. Data are also provided on Title VI-B flow-through federal funds for preschool and school-age special education, as well as school district data on total enrollment and the total number and percentage of students with exceptionalities served.
ERIC Document #: ED386008

Financing Mental Health in Schools
Consultation Cadre List:

Note: Listing is alphabetized by Region and State as an aid so you can find and network with resources closest to you.

Our list of professionals is growing daily. Here are a few names as a beginning aid.

East

District of Columbia
Ronda Talley
425 Eighth Street, NW, #645
Washington, DC 20004
Phone: 202/393-0658
Fax: 202/393-5864
Email: rct.apa@email.apa.org

Maine
Ellen Bowman
LCPC-Clinical Counselor
Maranacook Community School-Student
P.O. Box 177
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Maryland
Kristin Langlykke
Maternal and Child Health Bureau
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5600 Fisher Lane
Rockville, MD 20857
Phone: 301/443-4026
Email: ncemch01@gumedlib.dml.georgetown.edu

New York
Christopher Cinton
Project Director
Bronx-Lebanon Hospital Center
1650 Grand Concourse
Bronx, NY 10457
Phone: 718/960-1328
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Pennsylvania
Patricia Welle
Student Services Coordinator
School District of the City of Allentown
31 South Penn Street, P.O. Box 328
Alllentown, PA 18105
Phone: 610/821-2619
Fax: 610/821-2618

Rhode Island
Robert F. Wooler
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82 Pond Street
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Southeast

Alabama
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Virginia

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Southwest

California

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Southwest (cont.)

California (cont.)

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FUNDING SOURCES FOR SCHOOL BASED HEALTH PROGRAMS

SOURCE OF FUNDS/CATEGORIES	HOW TO ACCESS OPTIONS	USE OF REVENUES IN BALTIMORE
General Funds: Local		
Health Dept. Budget	Determined by municipal government See local Health Departments	Budget for school nurses, aides, MDs, clerical, administration
Federal:		
EPSDT Administrative	Application to State EPSDT Office for administrative federal financial participation for expenditures related to outreach and case management that support the effort to assure pregnant women and children with MA or likely to be eligible for MA receive preventive health services	Applied to school nurse salaries who provide administrative outreach and case management Results in having local funds available for the SBC program
Title V (C and Y)	Application to agency delegated by State to distribute funds for primary health care for uninsured children.	Supports core staff in 3 school-based health centers.
STATE: Legislative	Bill initiated by state senator	$41,000 for 1 PNP in designated school
HMO Reimbursement Out of Plan Family Planning Provider (SBHC)	Per State HMO contract, bill HMO for Family Planning services as out of plan provider	Added to resource pool for expanding services in school clinics.
Pre-authorized services (SBHC)	Contract to complete EPSDT screens for HMO enrollees in SBHC schools.	Fee for service reimbursement
Fee for service: School-Based Clinics (SBHCs)	Apply for Medicaid Provider status. Arrange for revenues to be retained by program without requirement to spend in year of receipt.	Used to expand staff with part-time NPs, Medical assistants, physician preceptors, and contracts for mental health clinicians

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SOURCE OF FUNDS/CATEGORIES	OPTIONS	USE OF REVENUES IN BALTIMORE
Fee for service: School Nurse Programs	Apply for Medicaid provider number as LHD or LEA for medically necessary services provided in schools e.g. IEP nurse services .	Used to retain positions cut in local funds budget, provide education benefits for nurses, purchase equipment, add clerical support
Health Related services IEP/IFSP	Application to Medicaid as provider reimbursement for services provided to school children under IEP/IFSP. School Districts can apply directly for provider status or enter into a Letter of Agreement with a local health department and provides services as a clinic of local health dept. Uses specific LHD provider number. Agencies described above apply to state Medicaid.	Produces a significant revenue base that can support entire SBHC programs as is done by Baltimore County. Baltimore's MO between Health and Education stipulates that revenues must be used to expand or initiate expanded health services in schools. 38 school nurse positions, CHN Supvr, 6 Aides, social workers, 57 school-based mental health clinics, assistive technology equipment and a portable Dental Sealant Program for elementary schools
Case Management for Pediatric AIDS	Have school or clinic nurse provide case management for HIV positive children in schools through cooperation with local Pediatric AIDS Coordinator.	New option in Maryland
Home-based services & Service Coordination services	Apply for or include in MA provider application. Available for school nurses who complete required assessments and follow-up for eligible children	Not used in Baltimore schools
Targeted Case Management under Healthy Start		Not used

Source.
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Baltimore City Health Department

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Headlines

SCHOOL-BASED HEALTH CENTERS SEARCH FOR FUNDING
Eye Managed Care Organizations as Partners

By Alpha Center
State Initiative's Newsletter September/October 1995

Story - DOS Text Format

SCHOOL-BASED HEALTH CENTERS SEARCH FOR FUNDING
Eye Managed Care Organizations as Partners

With the growth of Medicaid managed care, school-based health centers have seen their reimbursement dollars drop at an alarming rate. In 1994 alone, the Baltimore City Health Department witnessed declines in Medicaid revenue of 35 percent for its school-bassed health centers as a result of managed care. During that same year, school-based health centers in the Bronx estimated a loss of $30,000 in Medicaid revenue for services they provided to managed care enrollees.

It is a trend that proponents of school-based health centers are watching with great trepidation. But it is also motivating administrators of these centers to negotiate with managed care plans in hopes of not only stanching the revenue bleeding, but possibly securing a steady source of funding. At the same time, a partnership with managed care plans would help place school-based health centers in the mainstream of health care delivery and improve care coordination for school-aged children.

The majority of students seen in school-based health centers are uninsured, with between 30 percent and 35 percent of the students on Medicaid. But as more states expand Medicaid coverage to uninsured children, that will ensure that a larger pool of children in high schools will receive coverage. At the same time, however, more and more states are enrolling their Medicaid populations into managed care plans. "If school-based health centers do not become part of that system, they will cease to exist," predicts Karen Hacker, of the Boston Department of Health and Hospitals.

Financial survival isn't the only reason for linking with managed care. According to Donna Zimmerman, executive director of Health Start, Inc. in St. Paul, Minnesota, and president of the new National Assembly on School-Based Health Care, the advantages are three-fold. First, negotiating with managed care organizations to reimburse services provided at school-based health centers will stop a backward slide in overall reimbursements. The new relationship will also ensure that students don't have "to be taken out of a system of care that they've become accustomed to," says Zimmerman. Furthermore, a large managed care organization has greater resources that could be used to assist clinics with quality improvement programs or staffing.

But partnering with managed care organizations is not easy. The barriers are many, ranging from having to prove a school-based center's effectiveness to negotiating an acceptable reimbursement rate and developing more sophisticated billing and information systems. "Nobody's going to contract with them just because they're the good guys," says Sandra Maislen of the Boston-based Neighborhood Health Plan.

Despite Financial Uncertainty, School-based Health Centers Are Growing

School-based health centers have been in operation since the 1970s. The centers began to grow in numbers with major expansions in Connecticut, Oregon, Colorado and New York in the 1980s. But "in the last five years, the growth has simply been exponential," says Julia Graham Lear, director of the national program office for The Robert Wood Johnson Foundation's Making the Grade program, which

national program office for The Robert Wood Johnson Foundation's Making the Grade program, which directs funds to establish state and local partnerships for school-based health centers. Between 1993 and 1995, the number of sites grew from 400 to more than 650. And the amount of state general fund dollars allocated to these centers grew from a total of $9.2 million in 1992 to $22.3 million in 1994.

"The beauty of this system," says Lear, "is that school-based health centers provide comprehensive, on-site, professional care at no cost, or very low cost, to those who so badly need it. They are a means of bringing the patient and health care together in a site that is convenient for the child." Services provided at these centers range from treatment of acute illnesses and injuries, to mental health services and counseling, to preventive care and management of chronic illnesses.

Despite the growing popularity of school-based health centers, nearly all clinics are still searching for secure sources of funding. Traditionally, school-based health centers have obtained funding through federal (primarily Title V block grants), state and private grants. Patient revenue, primarily from Medicaid, accounted for less than five percent of total center support. Now, the grant sources that school-based health centers have relied on are likely targets of substantial cuts at both the state and federal levels, leaving school-based health centers to compete with many other groups in search of dwindling public health dollars.

"There's a lot of competition for whatever dollars are there," says Lear. "You cannot depend on state funding to support a system of care. It just doesn't work that way." So, in recent years, more centers have turned to Medicaid but found it to be an unreliable source as well. "Many school-based health centers were billing Medicaid and all of a sudden the Medicaid funds shifted to (managed care organizations)," says Zimmerman. To win back Medicaid dollars, school-based health centers must get better at negotiating with the organizations that now control Medicaid dollars.

Barriers To Working With Managed Care Organizations

Before managed care organizations will take school-based health centers seriously, the centers will have to prove that they can do a better job at providing care to children, says Sandra Maislen of the Boston-based Neighborhood Health Plan. "School-based health centers are a very mixed bag," she says. "There's no national standard for a school-based health center."

The greatest variety is in their staffing and the scope of services they provide. In fact, they can run the gamut from a 24-hour center with a physician on call and clear lines of communication with primary care providers to part-time centers operated by a nurse practitioner that shut down after school hours and during the summer months, leaving students to seek care elsewhere. Also, many centers do not clearly define the services they provide and have no firm idea of what they cost.

"One of the biggest issues is that many centers have never done any billing, so they have a hard time telling the HMO what their exposure is likely to be," says Zimmerman. Few clinics have any cost experience on which to base proposed charges. In addition, many of the services they provide, such as counseling or behavior modification aimed at preventing teen pregnancy or AIDS, are not reimbursable medical procedures. "Frankly, the health care world doesn't really want to pay for these things," says Maislen. She notes that managed care organizations certainly know the value of preventive care services and behavior modification, but adds "these kids don't stay in our plans long enough for us to recoup the benefits."

The Advantages May Outweigh The Administrative Problems

Nonetheless, Maislen's network is investing in school-based health centers. Maislen says the network is interested in working with the centers because the state has established standards for school-based health centers to make certain a basic quality of service is provided. The Neighborhood Health Plan views the schools as well-equipped to reach a population that has traditionally shied away from services. Twenty-two of the network's health centers have links with designated school-based sites throughout Boston, paying a capitated rate that takes into account such things as violence prevention. And the network is in the process of opening up the system so that any network member can receive care at any

school-based health center and the services will be reimbursed.

"We are where the patients are," says Zimmerman. For managed care organizations that must meet Medicaid mandates to screen a certain percentage of adolescents, school-based health centers are uniquely positioned to help them attain that goal. "We provide very good access to Medicaid patients for the health plans, and we have access to whole families by virtue of the children being in the schools," Zimmerman adds.

Besides, for some problems an adolescent is more likely to seek advice or care from a provider based in the school than a health plan doctor. "It's unlikely that a teenager is going to say to a parent 'I've got a vaginal discharge, do you think I need to be tested?'" offers Maislen.

Maislen suggests that school-based health centers have to start thinking more strategically, marketing specific programs to HMOs. In Boston, programs targeted at Asthma management, preventing motor vehicle accidents and stopping violence would go a long way, says Maislen. Such preventive programs can stop such traumatic indicents from happening, and the costs associated with these services are far less than those for treating accident and shooting victims.

Focusing on partnerships with managed care plans isn't the only key to survival. The centers need to seek out partnerships with state governments and other organizations to build a network of support. Centers also need to build relations with other groups of providers to secure their place as alternate sites of care for adolescents. While successful negotiations could lead to more Medicaid revenue, those reimbursements will never be enough to fully fund center operations. According to Zimmerman, school-based health centers will always have to search out alternate sources of funding.

Examples of Federal Resources

To illustrate the range of federally funded resources, the following table was abstracted from 'Special Education for Students with Disabilities.' (1996). *The Future of Children*, 6(1), 162-173. The document's appendix provides a more comprehensive table.

What follows is a table composed of a broad range of federally supported programs which exist to meet specific needs of children and young adults with disabilities. Services include education, early intervention, health services, social services, income maintenance, housing, employment, and advocacy. The following presents information about programs that

- are federally supported (in whole or in part)
- exclusively serve individuals with disabilities or are broader programs (for example, Head Start) which include either a set-aside amount or mandated services for individuals with disabilities.
- provide services for children with disabilities or for young adults with disabilities through the process of becoming independent, including school-to-work transition and housing
- have an annual federal budget over $500,000,000 per year. (Selected smaller programs are also included).

Category	Program	Purpose	Target Population	Services Funded
Education	Special Education-State Grants Program for Children with Disabilities US Dept. of Education, Office of Special Education Programs contact: Division of Assistance to States, (202) 205-8825	To ensure that all children with disabilities receive a free, appropriate public education (FAPE). This is an entitlement program	Children who have one or more of the following disabilities and who need special education or related services: Mental retardation, Hearing impairment, Deafness, Speech or language impairment, Visual impairment, Serious emotional disturbance, Orthopedic impairments, Autism, Traumatic brain injury, Specific learning disabilities, Other health impairments	Replacement evaluation, Reevaluation at least once every 3 years, Individualized education program, Appropriate instruction in the least restrictive environment
Comprehensive Services to Preschool Children	Head Start US Dept. of Health and Human Services contact: Head Start Bureau, (202) 205-8572	To provide a comprehensive-array of services and support which help low-income parents promote each child's development of social competence	Primarily 3- and 4-year-old low-income children and their families Statutory set-aside requires that at least 10% of Head Start enrollees must be disabled children	Education, Nutrition, Dental, Health, Mental health, Counseling/psychological therapy, Occupational/physical/speech therapy, Special services for children with disabilities, Social services for the family
Health	Medicaid US Dept. of Health and Human Services contact: Medicaid Bureau, (410) 768-0780	To provide comprehensive health care services for low-income persons This is an entitlement program	Low-income persons: Over 65 years of age, Children and youths to age 21, Pregnant women, Blind or disabled, and in some states- Medically needy persons not meeting income eligibility criteria	Screening, diagnosis, and treatment for infants, children, and youths under 21; Education-related health services to disabled students; Physician and nurse practitioner services; Rural health clinics; Medical, surgical, and dental services; laboratory and x-ray services; nursing facilities and home health for age 21 and older; Home/community services to avoid institutionalization; family planning services and supplies.
Health	Disabilities Prevention US Dept. of Health and Human Services, Centers for Disease Control and Prevention contact: Disabilities Prevention Program, (770) 488-7082	Funds educational efforts and epidemiological projects to prevent primary and secondary disabilities	Persons with: Mental retardation, Fetal alcohol syndrome, Head and spinal cord injuries, Secondary conditions in addition to identified disabilities, Selected adult chronic conditions	Funds pilot projects that are evaluated for effectiveness at disability prevention; Establishes state offices and advisory bodies; Supports state/local surveillance and prevention activities; Conducts and quantifies prevention programs; Conducts public education/awareness campaigns

Category	Program	Purpose	Target Population	Services Funded
Health	Maternal and Child Health Services US Dept. of Health and Human Services contact: Maternal and Child Health Bureau, (301)443-8041	To provide core public health functions to improve the health of mothers and children	Low-income women and children; Children with special health needs, including but not limited to disabilities	Comprehensive health and related services for children with special health care needs; Basic health services including preventative screenings, prenatal and postpartum care, delivery, nutrition, immunization, drugs, laboratory tests, and dental; Enabling services including transportation, case management, home visiting, translation services
Mental Health	Comprehensive Mental Health Services for Children and Adolescents with Serious Emotional Disturbances and Their Families US Dept. of Health and Human Service contact: Child, Adolescent and Family Branch Program Office, (301) 433-1333	The development of collaborative community-based mental health service delivery systems	Children and adolescents under 22 years of age with severe emotional, behavioral, or mental disorders and their families	Diagnostic and evaluation services; Individualized service plan with designed case manager; Respite care; Intensive day treatment; Therapeutic foster care; Intensive home-, school-, or clinic-based services; Crisis services; Transition services from adolescence to adulthood
Social Services	Foster Care US Dept. of Health and Human Services contact: Children's Bureau, (2020) 205-8618	To assist states with the costs of: foster care maintenance; administrative costs; training for staff, foster parents, and private agency staff. This is an entitlement program	Children and youths under 18 who need placement outside their homes	Direct costs of foster care maintenance; placement; case planning and review; training for staff, parents, and private agency staff
Housing	Supportive Housing US Dept. of Hosing and Urban Development (HUD contact: Local Housing and Urban Development field office	To expand the supply of housing that enables persons with disabilities to live independently	Very low-income persons who are: blind or disabled, including children and youths 18 years of age and younger who have a medically determinable physical or mental impairment and who meet financial eligibility requirements; over 65 years of age	Cash assistance Average monthly payment is $420 per child with disability. Range is from $1 to $446

A Proposal Writing Short Course

Introduction

The subject of this short course is proposal writing. But the proposal does not stand alone. It must be part of a process of planning and of research on, outreach to, and cultivation of potential foundation and corporate donors.

This process is grounded in the conviction that a partnership should develop between the nonprofit and the donor. When you spend a great deal of your time seeking money, it is hard to remember that it can also be difficult to give money away. In fact, the dollars contributed by a foundation or corporation have no value until they are attached to solid programs in the nonprofit sector.

This truly *is* an ideal partnership. The nonprofits have the ideas and the capacity to solve problems, but no dollars with which to implement them. The foundations and corporations have the financial resources but not the other resources needed to create programs. Bring the two together effectively, and the result is a dynamic collaboration.

You need to follow a step-by-step process in the search for private dollars. It takes time and persistence to succeed. After you have written a proposal, it could take as long as a year to obtain the funds needed to carry it out. And even a perfectly written proposal submitted to the right prospect may be rejected.

Raising funds is an investment in the future. Your aim should be to build a network of foundation and corporate funders, many of which give small gifts on a fairly steady basis and a few of which give large, periodic grants. By doggedly pursuing the various steps of the process, each year you can retain most of your regular supporters and strike a balance with the comings and goings of larger donors.

The recommended process is not a formula to be rigidly adhered to. It is a suggested approach that can be adapted to fit the needs of any nonprofit and the peculiarities of each situation. Fundraising is an art as well as a science. You must bring your own creativity to it and remain flexible.

Gathering Background Information

The first thing you will need to do in writing the master proposal is to gather the documentation for it. You will require background documentation in three areas: concept, program, and finance.

If all of this information is not readily available to you, determine who will help you gather each type of information. If you are part of a small nonprofit with no staff, a knowledgeable board member will be the logical choice. If you are in a larger agency, there should be program and financial support staff who can help you. Once you know with whom to talk, identify the questions to ask.

This data-gathering process makes the actual writing much easier. And by focusing once again on mission and available resources, it also helps key people within your agency

again on mission and available resources, it also helps key people within your agency seriously consider the project's value to the organization.

Concept

It is important that you have a good sense of how the project fits into the philosophy and mission of your agency. The need that the proposal is addressing must also be documented. These concepts must be well articulated in the proposal. Funders want to know that a project reinforces the overall direction of an organization, and they may need to be convinced that the case for the project is compelling. You should collect background data on your organization and on the need to be addressed so that your arguments are well documented.

Program

Here is a check list of the program information you require:

the nature of the project and how it will be conducted;
the timetable for the project;
the anticipated outcomes and how best to evaluate the results; and
staffing needs, including deployment of existing staff and new hires.

Financials

You will not be able to pin down all the expenses associated with the project until the program details and timing have been worked out. Thus, the main financial data gathering takes place *after* the narrative part of the master proposal has been written. However, at this stage you do need to sketch out the broad outlines of the budget to be sure that the costs are in reasonable proportion to the outcomes you anticipate. If it appears that the costs will be prohibitive, even with a foundation grant, you should then scale back your plans or adjust them to remove the least cost-effective expenditures.

Components of a Proposal

1. **Executive Summary:**
   umbrella statement of your case and summary of the entire proposal
   1 page

2. **Statement of Need:**
   why this project is necessary
   2 pages

3. **Project Description:**
   nuts and bolts of how the project wil be implemented
   3 pages

4. **Budget:**
   financial description of the project plus explanatory notes
   1 page

5. **Organization Information:**
   history and governing structure of the nonprofit; its primary activities, audiences, and services

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audiences, and services
1 page

6. **Conclusion:**
summary of the proposal's main points
2 paragraphs

The Executive Summary

This first page of the proposal is the most important section of the entire document. Here you will provide the reader with a snapshot of what is to follow. Specifically, it summarizes all of the key information and is a sales document designed to convince the reader that this project should be considered for support. Be certain to include:

Problem — a brief statement of the problem or need your agency has recognized and is prepared to address (one or two paragraphs);

Solution — a short description of the project, including what will take place and how many people will benefit from the program, how and where it will operate, for how long, and who will staff it (one or two paragraphs);

Funding requirements — an explanation of the amount of grant money required for the project and what your plans are for funding it in the future (one paragraph); and

Organization and its expertise — a brief statement of the name, history, purpose, and activities of your agency, emphasizing its capacity to carry out this proposal (one paragraph).

The Statement of Need

If the funder reads beyond the executive summary, you have successfully piqued his or her interest. Your next task is to build on this initial interest in your project by enabling the funder to understand the problem that the project will remedy.

The statement of need will enable the reader to learn more about the issues. It presents the facts and evidence that support the need for the project and establishes that your nonprofit understands the problems and therefore can reasonably address them. The information used to support the case can come from authorities in the field, as well as from your agency's own experience.

You want the need section to be succinct, yet persuasive. Like a good debater, you must assemble all the arguments. Then present them in a logical sequence that will readily convince the reader of their importance. As you marshall your arguments, consider the following six points.

First, decide which facts or statistics best support the project. Be sure the data you present are accurate. There are few things more embarrassing than to have the funder tell you that your information is out of date or incorrect. Information that is too generic or broad will not help you develop a winning argument for your project. Information that does not relate to your organization or the project you are presenting will cause the funder to question the entire proposal. There also should be a balance between the information

question the entire proposal. There also should be a balance between the information presented and the scale of the program.

Second, give the reader hope. The picture you paint should not be so grim that the solution appears hopeless. The funder will wonder if this investment in a grant would be worth it. Here's an example of a solid statement of need: "Breast cancer kills. But statistics prove that regular check-ups catch most breast cancer in the early stages, reducing the likelihood of death. Hence, a program to encourage preventive check-ups will reduce the risk of death due to breast cancer." Avoid overstatement and overly emotional appeals.

Third, decide if you want to put your project forward as a model. This could expand the base of potential funders, but serving as a model works only for certain types of projects. Don't try to make this argument if it doesn't really fit. Funders may well expect your agency to follow through with a replication plan if you present your project as a model.

If the decision about a model is affirmative, you should document how the problem you are addressing occurs in other communities. Be sure to explain how your solution could be a solution for others as well.

Fourth, determine whether it is reasonable to portray the need as acute. You are asking the funder to pay more attention to your proposal because either the problem you address is worse than others or the solution you propose makes more sense than others. Here is an example of a balanced but weighty statement: "Drug abuse is a national problem. Each day, children all over the country die from drug overdose. In the South Bronx the problem is worse. More children die here than any place else. It is an epidemic. Hence, our drug prevention program is needed more in the South Bronx than in any other part of the city."

Fifth, decide whether you can demonstrate that your program addresses the need differently or better than other projects that preceded it. It is often difficult to describe the need for your project without being critical of the competition. But you must be careful not to do so. Being critical of other nonprofits will not be well received by the funder. It may cause the funder to look more carefully at your own project to see why you felt you had to build your case by demeaning others. The funder may have invested in these other projects or may begin to consider them, now that you have brought them to their attention.

If possible, you should make it clear that you are cognizant of, and on good terms with, others doing work in your field. Keep in mind that today's funders are very interested in collaboration. They may even ask why you are not collaborating with those you view as key competitors. So at the least you need to describe how your work complements, but does not duplicate, the work of others.

Sixth, avoid circular reasoning. In circular reasoning, you present the absence of your solution as the actual problem. Then your solution is offered as the way to solve the problem. For example, the circular reasoning for building a community swimming pool might go like this: "The problem is that we have no pool in our community. Building a pool will solve the problem." A more persuasive case would cite what a pool has meant to a neighboring community, permitting it to offer recreation, exercise, and physical therapy programs. The statement might refer to a survey that underscores the target audience's planned usage of the facility and conclude with the connection between the proposed usage and potential benefits to enhance life in the community.

The statement of need does not have to be long and involved. Short, concise information captures the reader's attention.

The Project Description

This section of your proposal should have four subsections: objectives, methods,

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This section of your proposal should have four subsections: objectives, methods, staffing/administration, and evaluation. Together, objectives and methods dictate staffing and administrative requirements. They then become the focus of the evaluation to assess the results of the project. Taken together, the four subsectors present an interlocking picture of the total project.

Objectives

Objectives are the measurable outcomes of the program. They define your methods. Your objectives must be tangible, specific, concrete, measurable, and achievable in a specified time period. Grantseekers often confuse objectives with goals, which are conceptual and more abstract. For the purpose of illustration, here is the goal of a project with a subsidiary objective:

> **Goal:** Our after-school program will help children read better.
>
> **Objective:** Our after-school remedial education program will assist fifty children in improving their reading scores by one grade level as demonstrated on standardized reading tests administered after participating in the program for six months.

The goal in this case is abstract: improving reading, while the objective is much more specific. It is achievable in the short term (six months) and measurable (improving fifty children's reading scores by one grade level).

With competiton for dollars so great, well-articulated objectives are increasingly critical to a proposal's success.

Using a different example, there are at least four types of objectives:

1. **Behavioral** — A human action is anticipated.

   Example: Fifty of the seventy children participating will learn to swim.

2. **Performance** — A specific time frame within which a behavior will occur, at an expected proficiency level, is expected.

   Example: Fifty of the seventy children will learn to swim within six months and will pass a basic swimming proficiency test administered by a Red Cross-certified lifeguard.

3. **Process** — The manner in which something occurs is an end in itself.

   Example: We will document the teaching methods utilized, identifying those with the greatest success.

4. **Product** — A tangible item results.

   Example: A manual will be created to be used in teaching swimming to this age and proficiency group in the future.

In any given proposal, you will find yourself setting forth one or more of these types of objectives, depending on the nature of your project. Be certain to present the objectives very clearly. Make sure that they do not become lost in verbiage and that they stand out on the page. You might, for example, use numbers, bullets, or indentations to denote the objectives in the text. Above all, be realistic in setting objectives. Don't promise what you can't deliver. Remember, the funder will want to be told in the final report that the project actually

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Remember, the funder will want to be told in the final report that the project actually accomplished these objectives.

Methods

By means of the objectives, you have explained to the funder what will be achieved by the project. The methods section describes the specific activities that will take place to achieve the objectives. It might be helpful to divide our discussion of methods into the following: how, when, and why.

> *How*: This is the detailed description of what will occur from the time the project begins until it is completed. Your methods should match the previously stated objectives.
>
> *When*: The methods section should present the order and timing for the tasks. It might make sense to provide a timetable so that the reader does not have to map out the sequencing on his own....The timetable tells the reader "when" and provides another summary of the project that supports the rest of the methods section.
>
> *Why*: You may need to defend your chosen methods, especially if they are new or unorthodox. Why will the planned work lead to the outcomes you anticipate? You can answer this question in a number of ways, including using expert testimony and examples of other projects that work.

The methods section enables the reader to visualize the implementation of the project. It should convince the reader that your agency knows what it is doing, thereby establishing its credibility.

Staffing/Administration

In describing the methods, you will have mentioned staffing for the project. You now need to devote a few sentences to discussing the number of staff, their qualifications, and specific assignments. Details about individual staff members involved in the project can be included either as part of this section or in the appendix, depending on the length and importance of this information.

"Staffing" may refer to volunteers or to consultants, as well as to paid staff. Most proposal writers do not develop staffing sections for projects that are primarily volunteer run. Describing tasks that volunteers will undertake, however, can be most helpful to the proposal reader. Such information underscores the value added by the volunteers as well as the cost-effectiveness of the project.

For a project with paid staff, be certain to describe which staff will work full time and which will work part time on the project. Identify staff already employed by your nonprofit and those to be recruited specifically for the project. How will you free up the time of an already fully deployed individual?

Salary and project costs are affected by the qualifications of the staff. Delineate the practical experience you require for key staff, as well as level of expertise and educational background. If an individual has already been selected to direct the program, summarize his or her credentials and include a brief biographical sketch in the appendix. A strong project director can help influence a grant decision.

Describe for the reader your plans for administering the project. This is especially important in a large operation, if more than one agency is collaborating on the project, or if you are

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using a fiscal agent. It needs to be crystal clear who is responsible for financial management, project outcomes, and reporting.

Evaluation

An evaluation plan should not be left for consideration as your project is winding down; instead, it should be built into the project. Including an evaluation plan in your proposal indicates that you take your objectives seriously and want to know how well you have achieved them. Evaluation is also a sound management tool. Like strategic planning, it helps a nonprofit refine and improve its program. An evaluation can often be the best means for others to learn from your experience in conducting the project.

There are two types of formal evaluation. One measures the product; the other analyzes the process. Either or both might be appropriate to your project. The approach you choose will depend on the nature of the project and its objectives. For either type, you will need to describe the manner in which evaluation information will be collected and how the data will be analyzed. You should present your plan for how the evaluation and its results will be reported and the audience to which it will be directed. For example, it might be used internally or be shared with the funder, or it might deserve a wider audience. Your funder might even have an opinion about the scope of this dissemination.

The Budget

The budget for your proposal may be as simple as a one-page statement of projected expenses. Or your proposal may require a more complex presentation, perhaps including a page on projected support and revenue and notes explaining various items of expense or of revenue.

Expense Budget

As you prepare to assemble the budget, go back through the proposal narrative and make a list of all personnel and nonpersonnel items related to the operation of the project. Be sure that you list not only new costs that will be incurred if the project is funded but also any ongoing expenses for items that will be allocated to the project. Then get the relevant costs from the person in your agency who is responsible for keeping the books. You may need to estimate the proportions of your agency's ongoing expenses that should be charged to the project and any new costs, such as salaries for project personnel not yet hired. Put the costs you have identified next to each item on your list.

Your list of budget items and the calculations you have done to arrive at a dollar figure for each item should be summarized on worksheets. You should keep these to remind yourself how the numbers were developed. These worksheets can be useful as you continue to develop the proposal and discuss it with funders; they are also a valuable tool for monitoring the project once it is under way and for reporting after completion of the grant.

To see what a portion of a worksheet for a year-long project might look like, click **here**.

With your worksheets in hand, you are ready to prepare the expense budget. For most projects, costs should be grouped into subcategories, selected to reflect the critical areas of expense. All significant costs should be broken out within the subcategories, but small ones can be combined on one line. You might divide your expense budget into personnel and

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nonpersonnel costs; your personnel subcategories might include salaries, benefits, and consultants. Subcategories under nonpersonnel costs might include travel, equipment, and printing, for example, with a dollar figure attached to each line.

Budget Narrative

A narrative portion of the budget is used to explain any unusual line items in the budget and is not always needed. If costs are straightforward and the numbers tell the story clearly, explanations are redundant.

If you decide a budget narrative is needed, you can structure it in one of two ways. You can create "Notes to the Budget," with footnote-style numbers on the line items in the budget keyed to numbered explanations. If really extensive or more general explanation is required, you can structure the budget narrative as just that — straight text. Remember though, the basic narrative about the project and your organization belong elsewhere in the proposal, not in the budget narrative.

Organizational Information

Normally a resume of your nonprofit organization should come at the end of your proposal. Your natural inclination may be to put this information up front in the document. But it is usually better to sell the need for your project and then your agency's ability to carry it out.

It is not necessary to overwhelm the reader with facts about your organization. This information can be conveyed easily by attaching a brochure or other prepared statement. In two pages or less, tell the reader when your nonprofit came into existence; state its mission, being certain to demonstrate how the subject of the proposal fits within or extends that mission; and describe the organization's structure, programs, and special expertise.

Discuss the size of the board, how board members are recruited, and their level of participation. Give the reader a feel for the makeup of the board. (You should include the full board list in an appendix.) If your agency is composed of volunteers or has an active volunteer group, describe the function that the volunteers fill. Provide details on the staff, including the numbers of full and part-time staff, and their levels of expertise.

Describe the kinds of activities in which your staff engage. Explain briefly the assistance you provide. Describe the audience you serve, any special or unusual needs they face, and why they rely on your agency. Cite the number of people who are reached through your programs.

Tying all of the information about your nonprofit together, cite your agency's expertise, especially as it relates to the subject of your proposal.

Conclusion

Every proposal should have a concluding paragraph or two. This is a good place to call attention to the future, after the grant is completed. If appropriate, you should outline some of the follow-up activities that might be undertaken to begin to prepare your funders for your next request. Alternatively, you should state how the project might carry on without further grant support.

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This section is also the place to make a final appeal for your project. Briefly iterate what your nonprofit wants to do and why it is important. Underscore why your agency needs funding to accomplish it. Don't be afraid at this stage to use a bit of emotion to solidify your case.

What Happens Next?

Submitting your proposal is no where near the end of your involvement in the grantmaking process. Grant review procedures vary widely, and the decision-making process can take anywhere from a few weeks to six months. During the review process, the funder may ask for additional information either directly from you or from outside consultants or professional references. Invariably, this is a difficult time for the grantseeker. You need to be patient but persistent. Some grantmakers outline their review procedures in annual reports or application guidelines. If you are unclear about the process, don't hesitate to ask.

If your hard work results in a grant, take a few moments to acknowledge the funder's support with a letter of thanks. You also need to find out whether the funder has specific forms, procedures, and deadlines for reporting the progress of your project. Clarifying your responsibilities as a grantee at the outset, particularly with respect to financial reporting, will prevent misunderstandings and more serious problems later.

Nor is rejection necessarily the end of the process. If you're unsure why your proposal was rejected, ask. Did the funder need additional information? Would they be interested in considering the proposal at a future date? Now might also be the time to begin cultivation of a prospective funder. Put them on your mailing list so that they can become further acquainted with your organization. Remember, there's always next year.

This short course in proposal writing was excerpted from *The Foundation Center's Center's Guide to Proposal Writing* (New York: The Foundation Center, 1993), by Jane C. Geever and Patricia McNeill, fundraising consultants with extensive experience in the field.

The Foundation Center's Guide to Proposal Writing and other resources on the subject are available for free use in **Foundation Center libraries** and **Cooperating Collections**.

Additional Readings

Burns, Michael E. *Proposal Writer's Guide*. New Haven, CT: Development & Technical Assistance Center.

Coley, Soraya M., and Cynthia Scheinberg. *Proposal Writing*. Newburg Park, CA: Sage Publications.

Gooch, Judith Mirick. *Writing Winning Proposals*. Washington, D.C.: Council for Advancement and Support of Education.

Hall, Mary. *Getting Funded: A Complete Guide to Proposal Writing*. 3rd ed. Portland, OR: Continuing Education Publications.

Kiritz, Norton J. *Program Planning and Proposal Writing*. Expanded version. Los Angeles, CA: The Grantsmanship Center

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Financing School-Based Health Centers

A guide for state officials regarding financing issues related to school-based health centers was prepared as part of the Making the Grade initiative and circulated in September 1995.[1]

The document begins with the following note of concern:

> *Despite the recent, unprecedented growth of school-based health centers and the related increased support from state governments, the future of school-based health centers is uncertain. Proposed cut-backs in government spending may limit previously available public health dollars and state governments that intended to include school-based health centers in their health care networks for school-aged children must now determine how to ensure financing for those centers.*
>
> *Given the fiscally conservative climate in Washington, D.C., states cannot rely on federal grant initiatives, federal protection fro cost-based reimbursement, or federal mandates for inclusion of school-based health center programs in Medicaid managed care arrangements. Nor can the states rely on private insurance or other commercial sources to support the centers. The expansion of privately financed managed care and the continuation of ERISA exclusions has eroded opportunities to enlist private dollars in support of school-based health centers. Each state must develop its own approach to supporting the centers.*

The document then provides some background on school-based health centers, discusses difficulties in financing them through third-party payments, explores other recent events that negatively affect their funding, and clarifies the importance of how centers are defined as related to financing policy. The paper concludes with the following presentation:

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[1] Issues in Financing School-Based Health Centers: A Guide for State Officials. (September 1995). Prepared by: *Making the Grade* National Program Office, The George Washington University, Washington, D.C.

For a related discussion, see Zimmerman, D.J. & Reif, C.J. (1995). School-based health centers and managed care health plans: Partners in primary care. *Journal of Public Health Management Practice, 1*, 33-39.

Strategies to Fund School-Based Health Centers: Alternative Reimbursement Models

Once the state has defined a school-based health center provider-type by identifying the community to be served and the services to be provided, the state must then address how the school-based health centers will be paid for their services. In so doing, the distinction between local and state perspectives must be considered. The individual school-based health center or its sponsor is responsible for covering its operating costs; the full range of alternatives from contracts with managed care plans to fee-for-service billing to categorical grant initiatives and in-kind contributions must be explored. Regardless of its creativity and energetic pursuit of financing, however, the health center's access to financial support will be determined, in great part, by decisions at the state level.

The level of state support for school-based health centers is a function of the combined decisions of all the state agencies that agree to participate in supporting care provided by the centers. It is therefore important that the broadest range of decision-makers sit at the table when determining what resources can be applied to school-based health centers. In general, the key participants will include the Medicaid director, the Commissioner of Public Health, the Superintendent of Schools, the Commissioner of Mental Health and, perhaps, the Insurance Commissioner. If special health care reform offices have been established, their involvement is essential as well.

To assure stable long-term financing for school-based health center programs, resolution of the following issues is critical: Should payment to the centers be on a fee-for-service basis? How are uninsured students to be covered? How can this program fit with managed care? Should state-supported programs be paid only through Medicaid, and if so, should they serve only the Medicaid-eligible population? Experience has shown that whichever model the state chooses to adopt must be accepted and supported at every level of state government.

There are a limited number of approaches for paying school-based health centers for the care they provide to designated populations. These include a regulatory approach, a market approach, and a "pooled fund" approach.

A regulatory approach

Under this approach, the state through its regulatory process defines the school-based health center provider-type, including the establishment of targeting criteria and services to be provided, and mandates that Medicaid managed care plans (and/or potentially all licensed insurers in the state) pay the provider-type for services provided to their enrollees at a stipulated rate determined to cover the costs of providing that care.

This approach is not dissimilar to some existing provisions under managed care. For example, family planning services are often "carved out" from the primary care contracts of Medicaid managed care providers. That is, although family planning is a covered benefit for which the managed care plan is responsible, enrollees may obtain family planning services outside the plan without going through their

primary care "gatekeeper." The managed care organization excludes family planning services from the per capita payment to the primary care provider, and pays the family planning organization on a fee-for-service basis. This is done because all parties want enrollees to have free access to family planning services, which would be less likely to occur if pre-approval were needed from the primary care gatekeeper.[4]

The regulatory approach has several benefits: it provides stable funding; it defines and codifies the school-based health care model; and it allows the state to determine the scope and breadth of the program. It also fits well within the traditional role of government in serving the low-income population. The necessary technology exists to implement the approach, since the centers will be serving in an established role, that is, they will operate as vendors to managed care plans.

There are also drawbacks: The percentage of school-age children for whom a school-based health center would receive payment under such an approach must be carefully assessed. Because states may lack adequate regulatory authority over self-insured plans (approximately half of all insured employees and dependents are insured through self-insured plans), the financing of school-based health centers will be largely dependent on Medicaid and other insurance plans regulated by the state. If only a small number of students are covered under Medicaid and other state-regulated plans, funding for the centers from this source will necessarily be limited.

From the perspective of the school-based health center, the regulatory approach calls for considerable administrative effort. The center will need to identify the managed care plan in which the student is enrolled (in general it is the parent, rather than the child, who is the direct enrollee, making identification sometimes very difficult). The center must then obtain all necessary billing numbers and generate a bill that meets the needs of the managed care plan. The problems faced by Medicaid managed care programs in managing the Medicaid population will be passed on to the center, and are likely to become magnified in the process. Notification of plan enrollment change by the parent may not be accomplished smoothly, and the problem of eligibility may become even more difficult. Representatives of Medicaid managed care plans complain that their greatest problem arises from involuntary disenrollment through loss of eligibility, which often affects 50 percent of their covered population annually.

Other complex problems may arise in a Medicaid managed care plan, including possible limitations on mental health services providers, and an unwillingness to reimburse for services of clinical social workers, who often play a major role in school-based health care. Moreover, the managed care plan may limit the number of outpatient mental health visits, or may require (as in New York State) that after 10 such visits the patient's care is shifted to a mental health managed care provider.

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[4] By a 1986 amendment to Title XIX of the Social Security Act, Congress "carved out" family planning from the Medicaid managed care programs under the 1915(b) waiver process to assure that Medicaid beneficiaries had broad access to family planning services. However, the carve out is not applicable to Medicaid managed care programs operating under Section 1115 waivers. See P.L. 99-509, Section 9508. Sara Rosenbaum et al., Beyond Freedom to Choose: Medicaid Managed Care and Family Planning, Center for Health Policy Research, The George Washington University, Washington, DC.

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Lastly, to participate efficiently within a managed care system, school-based health centers will need medical billing capability and full understanding of the complexities of health care accounting practices.

A market approach

Under the market approach, rather than identifying and certifying the school-based health center as an essential provider-type, the state would define the function of the school-based health center as an essential *service*. That is, the state would specify that if a managed care organization is authorized to serve an area with more than a certain percent of Medicaid enrollment, it must provide school-based health care services as part of its Medicaid contract.

Using this approach, it would be possible for managed care organizations to work collaboratively with community schools to ensure a sound, well-organized program. Collaboration, however, is by no means guaranteed. Several centers might be organized by competing plans in schools that are in close proximity to one another. Will the centers serve students who are not enrolled in the sponsoring plan? Indeed, there are a number of potential problems, including neglecting the sensitivities of the school itself. Some schools may not want a center either for political reasons or due to space scarcity. The issue of governance is also likely to be problematic: who would own the center and could it be owned by one plan, or by several together?

The question of accountability also arises. To whom would the managed care organization be accountable, and for what? Could students vote with their feet and obtain services elsewhere? Hypothetically, unless the managed care organization is held accountable for the services it provides via school-based health center standards, the plans may find it in their best interest to limit resources and make the program extremely unattractive. Without accountability, there will be limited acceptance of responsibility for the needs of the student, and an idiosyncratic program may well develop.

A "pooled fund" approach

Under the pooled funding approach, the state assumes direct responsibility for the program, and funds it via a global budget paid directly to each center. The state determines the centers' operating cost and creates a fund to pay for a specific number of centers by pooling money from a variety of sources. These include Medicaid funds obtained under 1115 waivers, federal maternal and child health funds, state general revenue support, foundation grants, and other related funds available through education and human services. By the state pooling these funds together, matching federal Medicaid funds under the terms of the 1115 waiver could be obtained. The project could then be administered by an appropriate state agency in accordance with defined targeting criteria and service levels as previously discussed.

In 1991, the New York legislature considered a variation of this approach. As reported by Christel Brellochs, proposed legislation sought "to take advantage of disproportionate share allowance provisions of the federal Medicaid program by designating the $3 million in State funds allocated to school-based health centers as the state contributions to Medicaid. If this amount were matched by local (25%) and federal (50%) shares, approximately $10 million would be generated for the school-based health centers. Combined with the Title V allocation of $3.5 million,

a total of $13.5 million would be available to fund school-based or school-linked services." The proposal was rejected by the New York Senate as a result of end-of-session politicking, but the New York experience suggests the possibility of this approach (Brellochs, 1992).

The model, however, has not been implemented in any state. As a result, there are a number of issues that will need to be resolved. The state must be able to monitor the management of global budgets by the centers to assure efficient operation. Incentives for optimum utility must be incorporated so that if a center's utilization rate is lower, it receives a smaller budget. At present, there are limited data available to inform the establishment of an appropriate budget based on utilization (that is, we don't currently know, in a high school of, for example, 1,000 students, what the normative budget for a school-based health center should be, or what might impact on that budget in terms of making it larger or smaller).

A major attraction of this approach is that currently-available funds, such as the Maternal and Child Health block grant program and private foundation grant awards such as those from the Robert Wood Johnson Foundation, the Kellogg Foundation, and the William Caspar Graustein Memorial Fund could be used to learn more about how to organize this kind of program and manage global budgets efficiently. It would then be possible to "carve out" the services and finances from state-sponsored Medicaid managed care programs, and continue the program as a direct state-supported operation with an appropriate global budget. The learning period could also be used to continue to build solid community support for the program. This includes working with the schools to assure their perception of ownership and working with community providers to develop sound referral relationships, an essential requirement for collaborating with managed care programs.

It seems as if we can see the future for school-based health center programs, as for all other health care endeavors, only in a glass darkly. Nonetheless, it seems possible that this kind of globally-budgeted program, funded by the state through pooling a variety of resources, may provide a sound interim step in learning not only how to fund the program for the longer term, but also how to implement it effectively through well-developed targeting and service criteria.

A comparative analysis of the three long-term financing approaches is summarized in Table 3 on the next page.

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Table 3. Alternative Reimbursement Models For State-Sponsored School-Based Health Center Programs

	Regulatory Model	Market Model	Pooled Fund
Accountability	Must meet state-defined criteria	Unclear	Managed by state dept. of health
Payment Mechanisms	State-stipulated per-unit rate (fee-for-service)	Determined by market	State-determined global budget
Administrative Burdens	High for all parties: state, centers and managed care plans	Low for states; market determines for managed care plans	Mid-level for states; minimal for centers and managed care plans
Student Evaluation	Choice limited to enrollment opportunities under Medicaid managed care	Unclear	State accountability process must include student assessment

Sources:

Brellochs, C. Initial report: School health Medicaid project. Center for Population and Family Health, Columbia University School of Public Health, New York. Report to the New York Community Trust, January 1992.

Rosenberg, S, et al. Beyond the freedom to choose: Medicaid managed care and family planning. Center for Health Policy Research, The George Washington University, 1994.

We hope you found this to be a useful resource. There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

CLEARINGHOUSE CATEGORIES

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards
- Other System Topics: _____

Programs and Process Concerns:

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics
- Other program and process concerns: _____

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning Problems
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness
- School Adjustment (including newcomer acculturation)
- Other Psychosocial problems: _____